MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

Ronald Reagan Building
International Trade Center
Horizon Ballroom
1300 13th Street, N.W.
Washington, D.C.

Thursday, October 10, 2002
10:18 a.m.

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair
ROBERT D. REISCHAUER, Ph.D., Vice Chair
SHEILA P. BURKE
AUTRY O.V. "PETE" DeBUSK
NANCY ANN DePARLE
DAVID DURENBERGER
ALLEN FEEZOR
RALPH W. MULLER
ALAN R. NELSON, M.D.
JOSEPH P. NEWHOUSE, Ph.D.
CAROL RAPHAEL
ALICE ROSENBLATT
JOHN W. ROWE, M.D.
DAVID A. SMITH
MARY K. WAKEFIELD, Ph.D.
NICHOLAS J. WOLTER, M.D.

AGENDA ITEM: New developments in Medicare+Choice -- Scott Harrison

DR. HARRISON: It just wouldn't be fall if I wasn't telling you about all the Medicare+Choice plans pulling out of the program, would it?

Currently, there are 155 Medicare+Choice coordinated care plans, or CCPs, and two private fee-for-service plans. For 2003, nine contracts are ending and another 24 are pulling out of some of the areas that they currently serve.

Because of these withdrawals, about 200,000 Medicare+Choice enrollees will not be able to stay in their current Medicare+Choice plans past the end of the year. Of those enrollees, about 36,000 live in counties where there is no other CCP available.

These numbers may be actually overstated for a couple of reasons. First, in the Kansas City area, one plan with 23,000 members is ending its contract because it's being bought by another M+C in the area. And second, about 50,000 of the enrollees losing their Medicare+Choice plans and about 11,000 of those with no other CCP available are accounted for by Kaiser members in the metropolitan Cleveland and Washington, D.C. areas.

In those areas, Kaiser is ending their Medicare+Choice contract but is switching the members into cost contracts that they currently hold. Therefore, those members will be able to stay with Kaiser. Bear with me in a few minutes and I'll remind you exactly what cost contracts are.

DR. REISCHAUER: [Off microphone.] So what you're saying is the second column should be 2,000? The 36,000?

DR. HARRISON: The 200,000 should be more like 125,000. But of the ones that don't have anything else available, that probably should be more like 25,000.

DR. REISCHAUER: [Off microphone.]

DR. ROWE: [Off microphone.]

MS. BURKE: [Off microphone.]

DR. HARRISON: Yes, and the fact that there are --

DR. ROWE: [Off microphone]. There's the one in St. Louis that's being bought by another one [inaudible].

DR. HARRISON: Right, so the contract is technically ending but those members, because they're being bought by another existing area plan can actually --

MS. BURKE: [Off microphone] but they're not in [inaudible].

DR. HARRISON: No, they're not in the 36,000.

MR. HACKBARTH: Could I ask people to take care to use your mikes? It really makes things easier later on for people who need to work with the transcript.

DR. HARRISON: Let's put this level of withdrawals in historical perspective for a minute. In simple terms, the level of pullouts is the least severe in the Medicare+Choice program's history.

As a general characterization, withdrawals in 1999 and 2000

were mostly smaller plans, plans that didn't have large market share, and plans that were trimming back their service areas after rethinking recent expansion.

In 2001 and 2002, major national plans made large or even total withdrawals. For 2003 we seem to returning to a general pattern of some withdrawals by smaller plans and the trimming of service areas by larger plans.

The pullouts this year did not seem to be concentrated in any particular types of geographic areas, urban, rural or floor or non-floor. They were pretty well disbursed. There were some local areas that were hit hard. Delaware, Indiana and South Dakota all lost their only plans. However, none of those plans had as much as 3 percent market share in the areas they pulled out of.

Sterling, which is the only multi-state private fee-for-service plan, continued its pattern of pulling out of some urban areas. It pulled out of Columbus, Ohio; Nashville; and San Antonio. Nationally, Sterling's withdrawals will affect about 8 percent of its enrollees.

We can look at how the pullouts affect Medicare+Choice availability to beneficiaries. I should note here that while we generally learn about the pullouts all at once, plans can enter the program and expand their service area throughout the year. For example, Marshfield Clinic has recently begun offering a plan to a large portion of Wisconsin. And a plan in Puerto Rico has expanded to cover much of the island. There have also been a couple of other, smaller expansions.

But as a result of the pullouts and the entries that we know of as of now, Medicare+Choice plans will be available to about the same percentage of beneficiaries next year as this year. More specifically, in January 2002, about 61 percent of beneficiaries had an M+C CCP available to them, and the same will be true in January 2003. About 34 percent of beneficiaries will have a private fee-for-service plan available, down from 36 percent.

In 2003, 78 percent of beneficiaries will have at least one of the two M+C choices.

Beneficiaries in urban areas are still about four times more likely to have a CCP available than rural beneficiaries, although that gap has narrowed from 2003, primarily due to the entrance of a couple of large rural plans.

About 84 percent of urban beneficiaries will have some type of alternative available, while about 62 percent of rural beneficiaries will have an M+C plan available. The urban choices are most likely to be coordinated care plans while the rural choice is most likely to be private fee-for-service.

What we don't know yet is how premiums in the benefit packages will change. That information should be available, I believe it will come out in early November.

CMS has had concerns about the Medicare+Choice program. CMS believes that more plans are needed in the program in some geographic areas in order to foster competition that would lead to efficiencies and health care delivery that would lower the growth and expenditures over time.

In its current form, the Medicare+Choice program does not provide beneficiaries with the range of choices that they had when they were in the working population where PPOs, not HMOs, are now the dominant delivery model. PPOs are popular with both employers and employees. For the most part, PPOs have not entered the Medicare+Choice program, leaving HMOs as virtually the only choice for beneficiaries.

CMS found there were several barriers to PPO participation in the Medicare+Choice program. One, Medicare+Choice rates were too low in some areas. Two, the Medicare+Choice limit on cost sharing hinders benefit design in some areas. The actuarial value of all cost sharing, including premiums and copayments related to basic Medicare services, cannot exceed the national average cost sharing amount for the traditional fee-for-service Medicare program, which is about $102 per month in 2003.

This cap had been troubling for insurers in high payment areas and would be even more of a problem for PPOs which often include substantial out-of-network cost sharing.

Another barrier has been that PPOs have been wary of entering a fully capitated program. In the commercial world, PPOs usually share the risk on medical costs with the employers that offer the PPOs to their employees. In many cases, the PPOs carry no medical risk and offer administrative services only contracts to self-insured employers.

So to encourage plan entry, CMS has initiated a demonstration program for PPOs. It will start in January and is scheduled to run for three years. CMS has approved demonstration waivers for 33 plans in 23 different states and they ill be available to 11 million Medicare beneficiaries. At this point, we don't know what the premiums and benefits will look like, however.

Why might a plan be attracted to offering a PPO product under the demonstration rather than under the regular Medicare+Choice program? In some areas, the demonstration will pay more than Medicare+Choice rates. The demonstration will pay the maximum of the current Medicare+Choice rates or 99 percent of the average per capita Medicare fee-for-service spending.

About a quarter of beneficiaries who will have one of these demo plans available to them will live in counties where the demonstration rate is higher than the Medicare+Choice rate.

The demonstration will waive the cost sharing limit that I mentioned a few minutes ago. Benefit consultants have stated that lifting the cap will allow plans to compete more effectively with Medigap for those beneficiaries who are willing to buy a higher priced product. This waiver may be particularly helpful in attracting PPOs to high cost areas where the cap is more likely to be constraining.

Perhaps the waiver has been an effective measure because most plans are going into relatively high cost area, including three in New York City alone.

The demonstration also allows for negotiated risk sharing between the plans and Medicare. Details of the risk sharing arrangements have not been released but apparently most of the demo plans are availing themselves of this option.

While the PPO demos may provide an additional option, they are not likely to expand choice to beneficiaries who don't already have choice. Of the more than 11 million beneficiaries who will have a PPO available, only about a half million do not already have a CCP available.

Although a couple of the PPO demos are targeted to rural areas, generally they're going into the rural areas. About 600,000 rural beneficiaries will have access to PPOs, but even those are already pretty well represented with CCPs. Only 150,000 don't already have a CCP available.

Generally, it appears that the PPOs are going into areas where there are already Medicare managed care options. It remains to be seen whether those who enroll in PPOs are coming from the coordinated care plans or from fee-for-service or Medigap options.

I'm going to skip and tell you about the cost contracts now. Some beneficiaries across the country have another alternative to the fee-for-service Medicare program available to them, and those are the cost HMOs.

Cost HMOs were the original HMOs in the Medicare program. They were designed to allow beneficiaries who had been in HMOs before they became eligible for Medicare to stay in those HMOs. Medicare pays cost HMOs their cost, as determined by a cost report, for providing basic Medicare benefits for their members, less the actuarial value of traditional Medicare cost sharing.

The beneficiaries generally cover this cost sharing through their monthly premiums. In addition, members are free to seek Medicare covered services outside of the HMO's network. If a beneficiary goes to a non-network provider, Medicare pays the provider its share of the Medicare-covered charge and the beneficiary is responsible for the usual Medicare copays.

While cost plans have been an attractive benefit package for some beneficiaries, past studies have shown that this option costs the Medicare program significantly more than serving beneficiaries in the traditional fee-for-service program.

Currently, there are 30 cost plans in operation and they have a total of 290,000 members. We would expect that to go up with Kaiser's switch. Under current law, new cost plans cannot be formed and existing plans must cease operation at the end of 2004. So cost plans are scheduled to go away. There are proposals on the Hill to extend them.

DR. ROWE: Can I ask just quickly on that, how much more was it costing Medicare, what percent?

DR. HARRISON: The studies are old, and I'd be reluctant to give you a particular number, but it was definitely double digit.

So, when you combine the availability of Medicare+Choice plans, PPO demo plans and cost plans, about 80 percent of beneficiaries live in counties where they will be able to enroll in an alternative to the traditional Medicare fee-for-service program, 85 percent of urban beneficiaries will have such a choice, while 62 percent of rural beneficiaries will. Urban beneficiaries may have a range of plans to choose from, while usually the only choice for rural beneficiaries is the private fee-for-service option.

As for county payment rates, 90 percent of beneficiaries who live in counties with payment rates above the floors have a plan available, while only 72 percent of beneficiaries in four counties have a plan available.

In summing all of this up, we might optimistically view the Medicare+Choice as stable and evaluate it by plan availability and the relatively small numbers related to plan withdrawals this year. However, we do not yet know what benefit and premium changes are in store for enrollees. Those changes could force many enrollees out of plans and back into the fee-for-service Medicare program. We will need to reserve our judgment until we see the benefits and the resulting enrollment in 2003.

The staff plans to continue doing a few things. We will examine the benefit packages, both for the Medicare+Choice and the PPO plans to compare them with each other and see what they look like with regard to Medigap plans.

The staff will request timely enrollment data from CMS to monitor the enrollment in the PPO demo to see if enrollees are coming from fee-for-service or existing Medicare+Choice options. We will also investigate cost plans to see whether maybe they could be viable options, particularly for areas without Medicare+Choice plans.

We will look at how beneficiaries are affected when Medicare+Choice options change, and we will follow legislative action on payments and report back to you.

MS. DePARLE: You may have already said this, Scott, but I lost track here. What is the total number now of beneficiaries who have lost an M+C -- this is not lost an M+C plan, but it's more the category of no M+C plan available, because some of these people were affected multiple times, right?

DR. HARRISON: Right. I think, before this round, I think I've seen the figure a little over 2 million.

MS. DePARLE: Yes, that sounds right.

I think you may have answered this question, too. I thought that the cost contracting was phased out in the BBA, and is that the track we are on, that this is not by --

DR. HARRISON: They were originally scheduled to be phased out. I know they were extended at least once. I know at one point the deadline was 2002. It may have even been extended twice, but now it is 2004.

MR. FEEZOR: Scott, the ones that dropped out this year tended to be smaller areas or smaller volumes, I mean, South Dakota, Indiana -- all right, you're confirming that.

I wonder, we keep looking at the drying up of the M+C program and sort of as a default of something that's unique about this market. I wonder if there have been any comparisons in terms of how maybe that has compared to the drying up of, say, managed care and the traditional commercial market. I think that might be an interesting example.

We have had a withdrawal of about 17 counties in five years, and I'm talking about in our under-65 population. So I think it might be helpful to sort of put that in perspective, that it may not be something that is necessarily a part of the Medicare, even though it's affecting it, it may be, in fact, that some of the

entities which are willing to take on such arrangements, are, in fact, significantly rechanneling from their overall market strategy.

DR. HARRISON: Right. We are going to try to look at that a little bit. Next month you may very well see a presentation that looks at payment areas. And to do the work on that, we have purchased some data on commercial market share, and we will try to trace what service areas look like in commercial plans --

MR. FEEZOR: Particularly, and even within that is they shift even in the commercial market, shifting from say a capitated risk over to more of a PPO arrangement. So I think that would be helpful.

A final thing that I would like to see, if there are beginning to emerge any qualitative or outcome differentials in these products compared to the, and I think that would always, we need to keep an eye on that if any of that is beginning to emerge.

MS. ROSENBLATT: I thought your concluding statements in the summary paragraph in the written material were very good, and I just want to make sure I have a sense of the timing. Because I think one of the things you said is it looks like it's going to be stable, but we really won't know until we see how enrollees move.

My expectation is you're going to see a lot of premium increases and a lot of reduced benefits and that that is going to cause a great degree of beneficiary shifting. So my question is will we have that information before we have to do any sort of written report?

DR. HARRISON: We won't have enrollment information before -- I wouldn't trust any -- if CMS did things really quickly, about mid-February is about as quickly as we could really expect to have solid data on enrollment.

MS. ROSENBLATT: So I think we're going to have to be real careful about any statements. I mean, you will have a better sense what you see what the premiums and benefits are, but I think you're going to have to be real careful about making any statements about stability without that kind of number.

I never knew a lot about cost plans, and I have forgotten what little I knew, but I remember that the little I knew said to me that these plans only worked for staff model HMOs, that it was very difficult to do it if you weren't a staff model, and I don't know that you hit on that.

DR. HARRISON: Well, I think these were the first-generation HMOs, I thin, yes.

MS. ROSENBLATT: Maybe if you could explain that, as part of your discussion of the cost plan, that would be helpful.

DR. WAKEFIELD: Scott, a question on the private fee-for-service. In the text, you mentioned that Sterling is multi-state, and that there is a second private fee-for-service plan. I am not familiar with that second one. I assume it is not --

DR. HARRISON: It's DuPage County, Illinois, and it's at Humana.

DR. WAKEFIELD: Is that like one county?

DR. HARRISON: Yes.

DR. WAKEFIELD: Early on with Sterling we had a sense or at least you heard that that was clearly a plan that was in an expansion mode. Do you have any sense at all about this other private fee-for-service plan about whether it is going to stay local or it's positioning itself to go multi-state?

DR. HARRISON: It's a demo, and I'm not sure, I think it was positioned just to deal with a particular local problem.

DR. WAKEFIELD: And they're dropping it, you think? So, anyway, local at best is what you're saying.

DR. HARRISON: I believe there are a couple of applications for private fee-for-service pending in CMS, but I don't know the nature of those.

DR. NEWHOUSE: Scott, did I hear you say that at the end one of your next steps was investigating the viability of cost HMOs for rural areas?

DR. HARRISON: Well, there has been some congressional interest from time to time about these plans; you know, does it make sense for us to force them away when we have beneficiaries in these areas who are happy.

DR. NEWHOUSE: Well, I mean, it's not surprising that the beneficiaries are happy that do have them. But to me it's an anomaly in at least two ways: One is that the general thrust of policy over the last several years has been to get rid of cost-based reimbursement as much as possible. That is clearly not what is going on here; and the second is an equity consideration. I mean, to have the cost-based HMOs available in some areas and not in other areas seems to me to be not good policy.

I agree with everything that has been said about they only work for staff HMOs, but in part we got them because we weren't willing to do risk contracting with especially Kaiser in the '70s or when Medicare started in the '60s. We said we invented this, but it seems to me policy, for good reasons, has gone away from it in other areas. We should learn something from that.

So, if anything, I thought, given the tone of what I was reading in the document, we were going to come to some kind of negative comment about cost-based HMOs, but then at the end, that we're considering them for -- I mean, it just doesn't make a lot of sense to me, both for policy reasons and for the analysis, that staff-model HMOs are not exactly what one sees in rural areas.

DR. HARRISON: One thing is that the cost HMOs haven't been evaluated vis-a-vis what the Medicare+Choice payment rates are. There could be some interest on the Hill in seeing if these things are any more costly than regular Medicare+Choice plans in some areas.

DR. NEWHOUSE: But Medicare+Choice rates are, if anything, less than traditional Medicare rates, right? I mean, so if cost base is losing traditional Medicare --

MR. HACKBARTH: Not in the floor areas.

DR. NEWHOUSE: Not in the floor areas.

DR. MILLER: But Scott, it's correct that any analysis we do on this is going to contemplate the questions that Joe is talking about.

DR. HARRISON: Absolutely.

DR. MILLER: Right. I think that is the point.

MR. DURENBERGER: Let me use Marshfield as an illustration, and I'm not speaking for them.

If you compare, on the equity issues, I am sure they have made a choice of not a cost-base, but whatever we call them, the CCB or something like that, made it on a very divided boat, and what I understand one of the issues was how do you make money, any money, when you're operating with half the amount of money to do the same thing as they get in Miami or some other part of the country. That is an equity issue I want to continue to raise as we get into some of these other areas.

But I can't leave what you said about inequities on cost base alone because I think there are a lot of experiences that I have had with cost-based contracts where Medicare is paying a lot less to get the same result as they are in some other parts of the country. So just on the issue of equity, which we can come back and visit, I need to get on the record with that.

DR. ROWE: First of all, Scott, I continue to find you to be a source of insight into this. You've been following this for a long time and seem to really understand it very well. I don't think we should be too encouraged by the fact that the percent of all enrollees who dropped out or who were affected this year is significantly lower than the last couple of years.

I think that what plans have done over the last couple years is evaluated their participation in a heterogeneous market across the United States, which different plans have different levels of efficacy in different markets based on their non-Medicare enrollments, and then that works in other things.

And they have evaluated where they can, in an economic way, participate in this program and where they can't, they have dropped out or they have changed the co-payments, et cetera, and then the next year they come back and take another look to those in the gray area, and they drop out of some more, and they kind of clean it up, and then they are done with that process.

So what happens after that is you pretty much don't, you get a drop-off in the proportion of individuals who are affected, and it doesn't mean things are better. In fact, things are probably very much exactly the same, and it doesn't mean that you can now expect to see growth either. I mean, it's just that's the way it is, unless there is some change in the program that is fundamental, that changes the equation for the plans as they evaluate it in a market-by-market basis. It's not bad or good, but I just don't think we should -- it's not a headline here that it's only 4 percent that are affected this year, as opposed to 10 last year or 15 the year before or at least that is my view. I don't know if Alice would agree how her firm approaches this.

MS. ROSENBLATT: Jack, that was my point. That I think a lot of the plans, the action they took, rather than withdrawing, was to increase premiums and cost sharing, and that therefore -- that's why I was pushing to get the enrollment numbers.

DR. ROWE: So you agree.

MS. ROSENBLATT: Right.

DR. REISCHAUER: Scott, could you or somebody else on the staff remind me what the rules are about access to Medigap, if

you leave a plan that you have been in for three or four years that remains in business, but it has raised its premiums or cut its benefit. Is the Medigap policy underwritten at that point or do you have -- I mean, I thought if the plan didn't disappear, you could only get a policy, well, if the insurer wanted, as underwritten.

DR. HARRISON: I think if you had been in for more than a year, and you didn't join up when you were 65, I think that is correct. You are underwritten, but let me see --

DR. REISCHAUER: If that is the case, then some of the reaction that Alice anticipates may be quite muted because these people are really captured, in a sense, which then creates all sorts of other problems.

DR. HARRISON: Last year there was a special enrollment period decreed by CMS which allowed basically everybody to go back -- anybody that who was in a plan to go back in. I don't know whether that is likely to be an annual event or what their thinking is on that.

MS. ROSENBLATT: Bob, I agree with you, that's a great question for us to get the answer to because it will affect what's going to happen.

MR. HACKBARTH: Scott, I have a couple questions about the PPO demonstration. You said that it is common in the private sector for PPOs to share financial risk, and I wanted to ask Alice and Jack whether, in fact, that is the case. Four or five years ago, when I was involved in this stuff, in fact, PPOs were not risk-bearing organizations. It was strictly discounted fees. Has that changed?

MS. ROSENBLATT: I'm not aware of any capitated PPOs, if that's what your question is.

MR. HACKBARTH: I'm not sure exactly what the risk-sharing entails here because they haven't publicized what the arrangements are, but I assume it involves sharing some risk for utilization patterns.

MR. FEEZOR: Glenn, if I could go back to my days as a regulator, that where, first off, it may vary by state, depending upon the structure of the regulator, whether anything that is risk bearing, in fact, then drops off insurance, but in some of the self-funded contracts, we are able to do something what I call up-side incentive, but not necessarily capitated, but Jack probably has some more recent data on that.

MS. ROSENBLATT: To the extent that the insurance company in an insured program, not an ASO program, has a set premium, that the insurance company for that year, until it can increase the premium, is fully on the risk. As I said, I don't know of any PPO arrangement where the providers are in a capitated arrangement. So the insurer is bearing the full risk for that year until it can increase the premium.

MR. HACKBARTH: You do see insured PPO arrangements, as opposed to only on the ASO side?

MS. ROSENBLATT: Oh, absolutely.

DR. REISCHAUER: What I think Scott is referring to is that the government makes you a payment that is equal to the M+C payment or 99 percent of fee-for-service, and you could sign an

agreement that if that proves to be inadequate, the government will pay part of your losses, and it will capture part of your profits, right?

DR. HARRISON: I think the structure is likely to look like you're going to negotiate with Medicare as to, say, an administrative percentage, and that stays fixed, and then there's a medical loss ratio implied with the rest, and I think that there are bands around the medical loss ratio.

DR. ROWE: I think there may be -- for instance, we don't currently participate in this program, so I am not certain, but I think the TriCare program, which is Department of Defense, used to be CHAMPUS, has like a corridor of a defined risk, and if you're within that, fine, and if you go beyond that, then there is some sharing of the risk from the part of the Department of Defense. Those kinds of arrangements are out there, but otherwise I agree with what Alice said.

MR. HACKBARTH: Let me cut to the chase. The problem, I thought, is that private plans are having difficulty, basically, competing with traditional Medicare. They are finding the rates that Medicare is willing to pay too low relative to their costs, and the plans currently participating in M+C are all the more restrictive than PPOs, in terms of their ability to control the utilization of services because they are closed networks, to varying degrees.

So, if the existing plans that are more closed are having difficulty competing with Medicare, and doing it at Medicare's costs, now we're talking about a more flexible arrangement with still fewer controls on the costs, it is unclear to me what the likelihood is that these organizations are going to be able to provide the Medicare benefit package at a cost lower than Medicare or are we just saying that we are going to risk share and agree this is an avenue for Medicare to systematically pay more than we would have paid in fee-for-service?

DR. ROWE: Is that a question?

MR. HACKBARTH: Sort of.

DR. REISCHAUER: Isn't the issue here that they don't have to provide the actuarial equivalent of Medicare's cost sharing when they set up the PPO structure?

DR. MILLER: Right. I think it's two pieces, in response to that comment. That is the first one. In the PPO, if you can draw more revenue in through a differential cost-sharing structure, that is one of the flexibilities of the demonstration, but I think the other issue kind of imbedded in your comment is how the plans can compete to provide, in the traditional structure, to provide the standard benefit is one question, but the way they have been competing is just to provide additional benefits, and that is what is getting driven out in the current system and then people are not taking them up relative to fee-for-service.

I think if somebody is entering with a PPO option and saying I can provide -- I mean, if this is the argument they are going to make -- I can provide the traditional Medicare benefit within this range, take some risk, have the beneficiaries cost structure be different and compete against fee-for-service in that

arrangement, but not necessarily provide the additional benefits that an M+C would be providing or in the past had provided.

Scott, I don't know if you --

DR. HARRISON: I think that the intention, probably on most of the PPOs is to provide a richer package than the M+C plans so that they will have a bigger total set of revenue, and I think the idea is to compete more with fee-for-service plus Medigap.

Alice, if you --

MS. ROSENBLATT: I don't know. Our various plans looked at the PPO, and we are not -- any of it was not in the demo.

DR. ROWE: We are. We are in the demo in several areas, and all the details aren't worked out, as Scott pointed out, but we see it as a way to try to continue to serve this population within a program that has somewhat more flexibility because of the waiver on the cost sharing. Whether that will wind up, how much of that waiver will be utilized and what the benefit package will wind up looking like, compared to the other, is I think yet somewhat uncertain. But I think that our decision to participate was based on the fact that we thought it could be no worse, and maybe better, because of the flexibility, and we want to participate in the population.

But the comparison for us always is I think the correct comparison has to be whatever program you are in versus traditional Medicare plus Medigap. This concept that we have here of comparing this program to traditional Medicare is half a loaf because the beneficiary out there, I think 83 percent of them or something like that in traditional Medicare, have Medicare supplemental insurance. And so when we're asking, we're going to increase the out-of-pocket payments for people beyond the cost-sharing arrangement, they still may not be even approaching what they are paying with respect to some of this other stuff.

So that is really the -- and this includes pharmaceuticals, et cetera -- so that is really the combination, and I think here one of the things that we do because of our data set structure maybe is we are always comparing these programs to traditional Medicare, and I think that that is less informative than a different comparison.

MR. HACKBARTH: What you say makes great sense. If we're trying to find ways to make this more flexible and make it more palatable to both plans and beneficiaries alike and allowing more flexibility on the cost sharing is a critical factor, it seems to me we ought to allow traditional M+C plans with closed networks do a demo with some flexibility on cost sharing and see if that sells in the market for, against the market for Medicare plus supplemental.

DR. ROWE: So the question is, is this a PPO demonstration or is this a pathway to increased cost sharing?

MR. HACKBARTH: Right. Yes. We're going to have to bring this one to a conclusion.

Thank you, Scott. We'll talk more about it later as well.